STATEMENT OF TERMINAL CONDITION

_____has been under my medical care and has been diagnosed with the

following terminal condition(s) _____

_____

It is my professional opinion that the condition is such that death will occur within 6 months or less regardless of the application of medical procedure.

Attending Physician_____ Date _____

*Contact Number :_____

Consumer/Legally Responsible Person Request

In view of the above statement, it is desired that dying not be prolonged by administration of cardiopulmonary resuscitation (CPR).

I understand that my request for a DMRDD contracted provider to comply with a non-hospital DNR order is subject to Department approval. If my request is not accepted, I have the right to appeal the decision and have been notified of the appeals process.

_____ Date_____
Competent Adult / Legally Responsible Person

FOR DMH USE ONLY

I authorize / do not authorize the application of a non-hospital DNR order in the event cardiac and/or pulmonary arrest of the consumer as a result of a terminal condition by a DMRDD contracted/funded provider.

_____ Date_____
Medical Director or Designee

Comments: (more information needed, reason denied, etc.)

REVOCATION of AUTHORIZATION

I hereby revoke the above request to withhold CPR.

_____ Date: _____
Competent Adult / Legally Responsible Person